IMPLICATIONS FOR PHYSICIANS*

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WHEN I learned about my assignment in this program, I started looking through old *New Yorker* magazines for a cartoon that appeared 20 years ago and that I wanted to present to you as a slide. Although I could not find it, I can describe it to you. Picture a scene in a doctor's office. A rather woebegone looking man with his shirt off is sitting on the desk of the doctor who is on the telephone and the doctor is saying, "Well, dear, if it is something you have to have, go ahead and buy it, we will get the money somewhere." That attitude reflects the mood of the time.

Since 1965 society has said specifically to the aged and the poor, through Medicare and Medicaid, but also to the great mass of the employed, through employer-paid tax-exempt first dollar coverage, through Blue Cross and Blue Shield plans, and through commercial insurance for health care, "Don't worry about the cost of hospital and physician care; your insurance will cover it, whatever the cost is." The cumulative effect of this message delivered by the taxing system, the insurance payment mechanism, and the inevitable expansion of entitlement groups through politics, has been to insulate patients and providers from price consciousness on the part of patients and physicians. Our population has grown, technology has exploded, the expectation of miracles has burgeoned, and the cost of health care has outstripped its main actual cause, namely, inflation in the costs of goods and services.

In the early years of the 1980s, however, the message has changed. Politicians, government bureaucrats, labor, business and industrial management, health insurers and many health care providers are now saying, "Hold it! We are spending a greater share of our resources for health care than we think we want to, and the doctors and the hospitals are responsible." So the physicians and the hospitals, of course, are pointing the finger at each other, and back at government, labor and society as a whole, for generating an uncontrollable and unrealistic demand for health care (or sickness care) while

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at the same time they have been refusing to embrace changes in lifestyle—diet, alcohol, and other substance abuse, exercise, highway, workplace, and home safety—that could reduce sickness and injury to affordable levels if people would pay attention to the life-style factors that affect health status.

There has been a national decision to slow the growth, or even to halt the growth of the portion of the health care dollar—of which in the 1970s hospitals took 40 cents and physician services took about 19 cents. The decision has been made to limit the size of the pie, and the weapon that has been chosen by the present administration, at least, is competition: a social arrangement by which life is made hell for providers, supposedly to make life cheap and easy for consumers. By hell for providers, I mean physicians and hospital administrators and many other providers of health care. I acknowledge the feeling of many physicians that they do not like to be called providers; we prefer to be called personal physicians and we try to carry out those functions. But, like it or not, competition is upon us. Changes have produced a very competitive environment in the health care field. I am here to discuss with you what form those changes have taken and to try to give you the perspective of physicians.

I am medical director of the largest health maintenance organization in my state. I have often said that as a participant in prepaid group practice I have been a token representative of the health maintenance organization industry in the hierarchy of the American Medical Association, specifically as a member of the Council on Medical Service on which I am serving my third term. At the same time I have been a token representative of organized medicine on the National Industry Council for HMO development, an advisory council to the Secretary of the Department of Health and Human Services and the Office of Health Maintenance Organizations. I have served under five secretaries, and have seen that Council change from liberal-labor domination to a currently comparatively conservative domination by insurance, business, industry, with labor and additional representation from the medical profession, all of which I think is to the good, but there are those who will question that.

I would like to take you through some of the factors affecting the growth of the various delivery and financing systems. You have heard quite a bit about cost so I am not going to go into it. The fact is that the insurance companies and the business world, which we as a conservative medical profession used to think were very much on our side, have taken it upon themselves to demand that organized medicine address the matter of escalating cost. They have not always been willing to do so, and certainly are not now

willing to accept the pat on the head and our assurance that we shall control health care costs by "voluntary effort." The business coalitions, some of which have chosen to include physician representation but many of which do not, are telling us that costs are going to be controlled. I want to tell you that at least at the leadership level and increasingly at the grass-roots level, organized medicine is convinced that it must participate in the curtailing of health care costs. Of course, one of the reasons for this has been the growth in population of physicians. Between 1939 and 1982 the number of physicians per 1,000 increased by 40%, while the population increased by 20%, so that the law of supply and demand may be just beginning to work. Until now, the number of physicians per population unit in the metropolitan areas has only meant an increase in cost, as individual practitioners have found things to do for people which they could be paid for on a fee-for-service basis without having to cheat in any way. It has been possible for doctors to convince themselves that they have been doing what patients need and what patients want: "If one is good, two is better; why not do three?" This is the attitude that is undergoing change. This has resulted in the development and growth of numerous delivery and financing systems: health maintenance and preferred provider organizations, to be sure, but also ambulatory surgery centers and free standing ambulatory care centers.

The euphemism "health maintenance organization" as a description of prepaid group practice goes back to the Nixon administration, when Paul Ellwood coined the term, and the Nixon administration made a determination that prepaid capitated care was the way to go. We are told that the present attitude of the Reagan administration is very favorable toward capitation. We are all aware of that. The objective in 1973 was to point out that the third letter of HMO is 0, for organization. It is an organized system. Some people think that is good. Others think that the practice of medicine by organizations and corporations is impersonal, constricted, and repressed. I personally voted with my feet 15 years ago, in the belief that this system needed to be tested by doctors with whom I would be proud to associate myself. I participated in the founding of a multispecialty group that ran on a collision course with the Blue plans in my community. The Blue Shield plan was owned by the Medical Society of Milwaukee County, of which I was past president and a director. This is how my particular medical group got into prepaid group practice. There was pressure from politicians, labor, and the community at large to do some experimentation. We thought it couldn't hurt. We found out it could. There was a tremendous amount of opposition, but we have survived and an increasing number of physicians are finding that group practice is a viable alternative in financing health care.

There are important differences between the three kinds of health maintenance organizations. Prepaid group practices are divided into staff models and group models. In the staff models, physicians are employees of the plan, whereas in the group practice model the partnerships or groups of physicians contract with the plan to provide the care on a per month, per member capitation, which the group distributes by whatever means it chooses—by salary, by productivity, or by complicated formulae including both. The other kind is the independent practice association, the major distinction here is that the physicians practice in their own office settings, which many patients, of course, find desirable for many reasons, and most physicians in independent practice associations are paid in some degree on a fee-for-service basis.

The particular group model in which I first became involved has now become a network of group practices and independent practice associations that extends across Wisconsin, now serves about 225,000 subscribers, the fastest growing Blue Cross/Blue Shield subsidiary HMO in the country. The numbers of HMOs in the United States and of individuals enrolled in HMOs have grown very rapidly. The number of staff models has remained stationary; that is traceable, we think, to the withdrawal of government subsidies, grants and loans for feasibility studies and actual start-up functions, and the loans for brick and mortar. The staff models have reached a plateau, but independent practice associations have outstripped the group models, principally because of the physicians' determination to retain control and their belief that they function better in their own offices than under one roof with other physicians. Most people do not realize that private funding has always been the major source of capital for development of HMOs, but since the changes in 1980-1982, private enterprise has for all practical purposes completely taken over the provision of capital.

The distinction between for-profit and not-for-profit HMOs, in my opinion, is unimportant. The struggle to produce and to "market" an acceptable quality of care over the long haul means perhaps some dollars to private enterprise in for-profit corporations, but it means survival to the not-for-profit. When one thinks about the state requirements and regulations for reserves and the perquisites that administrators of not-for-profit operations take for themselves, for-profit or not-for-profit status need not really affect the quality of care the HMOs try to provide. Of course, that is extremely dependent upon the strength and the unity and the leadership of the physicians involved. The physicians have to be the watchdogs, the agents, and the advocates for the preservation of quality. If a physician does not feel that he can resist the pressures of not-for-profit or for-profit administrators to cut corners, he should not be involved in prepaid practice.

The American Medical Association's Council on Medical Services in 1980-81 conducted a landmark study on the quality, accessibility, and cost of care in HMOs. The report was generally favorable. Of course, we received a lot of anecdotal evidence of skimping, better described as disincentives to provide needed services, and skimming, the incentive to exclude the chronically ill, "high-user" of care. A good example of skimming that I heard about was an urban HMO under the new risk contract arrangements for Medicare that held its required open enrollment by widely advertising a bingo game to be held on the third floor of a warehouse with no elevator. Of course, if the potential subscriber was alert enough to want to play bingo and healthy enough to want to walk up to the third floor, he was an ideal candidate for the HMO. I do not suggest that that is a widespread practice, or even that the story is necessarily true. There are, of course, places where HMOs simply cannot operate because of distances, scattered population, and extremely satisfactory personal patient-physician relationships that exist in many rural areas and many towns and small cities. It seems certain that there has been a ripple effect of the efficiencies and economies that HMOs have been able to accomplish.

One of the most striking features of the second half of the 1980s is the determination of doctors to retain control. In my network of HMOs, several groups, for example, tested the water by becoming part of the Blue Cross/Blue Shield dominated network of groups and independent practice associations and then found that they could live with the prepaid mechanism but decided to get their own actuaries, marketing staff, and administration to separate themselves from control by an insurance company and to go it alone. That is the trend of the 80s, by either individual medical groups or even by medical societies. A prime example is the state medical association of Georgia, which has developed its own independent practice association with several thousand physician members.

With regard to HMOs for Medicare, my plan has always been involved on a fee-for-service basis and in some cases on a cost-contracting basis, but in 1985 and 1986 we have seen the change in the law so that it is possible for HMOs to undertake risk contracts, which will allow payment of 95% of the adjusted average per capita cost. That cost is determined locally on a very complicated formula, and of course is absolutely crucial to the ability of an HMO to provide decent care. It should be easy to discount what is being spent on the fee-for-service basis by 5%, but the fact is that the formula is so complicated that experience in several areas has been disastrous. On the contrary, in Milwaukee our actuaries tell us it will be possible to

provide a very high quality of care because of the difference in the average per capita cost in our county, compared to that in the center of the state. This is where physician groups must be extremely wary.

If I had had the idea 15 years ago to form a preferred provider organization, I think that is probably the way I would have gone. It is a nice idea to be able to form a group of physicians and obtain from them a commitment to discount their fees or, better still, just demonstrate that they have a good track record of cost-efficient and economical patient care, and sell the idea to subscribers by telling them: "If you pay us this premium we will take care of you if you come to us. If you want to go to somebody else, your basic hospital and physician costs will be covered, but you will have some copayments and deductibles." With no lock-in, no particular risk on the part of the physicians involved, it is very attractive. I am skeptical and the profession is skeptical of the long-term benefit of merely taking advantage of per-service discounts from physicians because it is easy to game the system by increasing the frequency of encounters. If one is going to be paid 15% less for each office visit, it is not hard to justify more visits. It is much more important, I think, to have shown that one will provide high quality of care at one's regular fair fee, that one will continue to do that, and to be willingly subject to monitoring. If one does not follow a pattern of efficient care, one's peers will have an opportunity to find it out, feed it back, look for self-correction or sanctions or to get rid of any physician not following an acceptable pattern of care, while at the same time protecting quality.

Preferred provider organizations cannot survive without effective utilization review and control. That is an advantage as far as patients and subscribers are concerned, of course, but many physicians look upon it as a disadvantage. The fact is, however, that these organizations are growing faster than the HMOs in numbers at present. Organized medicine, in looking at the "preferred provider" concept, raises the natural question, "preferred by whom?" The answer, of course, is "preferred by the carrier, the payor," whose emphasis on cost as opposed to quality may compromise the latter.

A word about ambulatory surgery centers which are proliferating rapidly. Right now most are hospital-owned but many entrepreneurs are taking advantage of the difference in the requirements for backup laboratory services and provision for catastrophic occurrences that hospitals must have but which ambulatory care centers are not required to have in many states. I do not think that these centers have a great future, in spite of the fact that much ambulatory surgery is being done. Most of it is being done in hospitals, and

most hospitals are providing better and better priced facilities for ambulatory surgery.

Finally, let us look at the ambulatory care centers. Many of us consider it a term describing another kind of doctor's office, simply marketed in a different way. It can definitely be used as an intake vacuum to fill hospital beds and is, of course, in many instances, resented by private practicing physicians. Some segments of the public consider ambulatory care centers as filling the void that is created in availability and accessibility when some physicians take off on Wednesday afternoons or after 5:00 P.M. One effect of the development of these centers has been a documented ripple effect, a widening of the practice of evening office hours by individual and group practitioners. Ambulatory care centers are most common in the Sunbelt, they are suburban, they offer weekend and evening hours and no continuity of care. And they are growing. Hospitals are finding these to be useful joint ventures with physician groups. Most are hospital owned, but some are becoming more and more independent. The fact is that physicians, as we all know, are forming themselves into groups because they are recognizing that it is almost impossible today to stand alone. One of the characteristics of women coming into medical practice is their determination not to make the practice of medicine the total of their lives, and I do not mean to stereotype that, but the fact is that they are teaching macho-male physicians that it is possible to be a loving person with a commitment to family as well as a physician.

I want to make one final statement about three policies of the American Medical Association. One is that there should be a fair marketplace determination of the survival of the various delivery mechanisms without government subsidy, but the decision should be made by patients and physicians as to the mode of practice that they wish. Second, that the choice of a provider should be free to everyone in so far as possible. We used to be able to include in the definition of an HMO that subscribers had chosen to prepay a group and to receive their care from a group. We can no longer say that because of economic restraints, employer restraints, government restraints in many states with Medicaid exemptions. So the freedom to choose is no longer 100% for physicians or for patients. Finally, when a patient makes a choice, he should make that choice responsibly, he should be well informed about the limitations he is accepting, and he should be willing to live with those limitations for the duration of the contract.

Organized medicine pledges its commitment to listen to grievances and to reconcile controversial issues and problems arising in all the forms of delivery systems.